Maryland Cancer Plan
Pain Management Committee

IDEAL MODEL FOR CANCER PAIN ASSESSMENT AND MANAGEMENT	The Pain Management Committee recognizes that the majority of cancer patients experience pain during the course of their illness. This symptom is often inadequately identified and managed. This Cancer Control Plan has the unique opportunity to address this serious public health challenge. The committee recognizes the complexity of the challenge. Our recommendations focus on access to and payment for care, education and training of health care professionals, patient/family education and public awareness, reform of the regulatory structure and process, and continued research. The overarching principles to be considered in the Maryland Cancer Plan regarding pain management are as follows. • **Access & Advocacy:** All cancer patients have the right to affordable, convenient, and effective pain assessment and multidisciplinary, multimodal pain management services. A mechanism should be developed to meet the pain management needs of the uninsured. Health professionals should advocate for patients in pain, particularly those who cannot advocate for themselves due to factors such as dementia, age, disability, and language barriers. • **Rights & Responsibilities:** All parties, including patients, providers and the health care system, have rights and responsibilities including but not limited to informed consent. • **Diversity:** All interactions occur with consideration to issues of disparity and cultural, religious, language, and age barriers of patients. *All individuals' life experiences contribute greatly to the complexity and uniqueness of the response to pain that we all face. These experiences, as much as anything, shape our desires and beliefs about health, illness and pain. The Pain Management Committee advocates for recognition, acceptance and support of its recommendations concerning individuals' experiences with race; historical oppression; cultural, religious and spiritual practices; affectional orientation; discrimination and poverty. The true meaning of diversity is as much about culture and lifestyle as about the narrower, yet more common concept that focuses on ethnicity or religion. (Adapted from the Last Acts website)* • **Extension of cancer pain to all pain:** Whereas: o cancer pain consists of acute and chronic pain, o the barriers to adequate assessment and management of cancer pain do not differ from pain management in non-malignant conditions, o the overarching principles of assessment and management are similar in malignant

	and nonmalignant pain conditions, o and under-treatment of pain is a public health problem We encourage that the recommendations in this document be extended to the management of acute and chronic pain associated with nonmalignant conditions.

PROBLEM or ISSUE	SOLUTION or RECOMMENDATION
Education and training: Lack of provider awareness and training regarding appropriate pain assessment, management and relevant regulatory issues. Targets for this comprehensive education include administrators and members of: • Health care systems • Licensing Boards including investigators • Professional organizations • Ethics Committees • Ombudsmen • State surveyors, regulators • Inspector General • Insurance Commission • Attorney General • Law enforcement personnel • Prosecutors • Judges • Medical examiners • Insurers	• Health care practitioners and students in all disciplines should receive both didactic and clinical training in pain assessment and management standards, which includes but is not limited to disparity issues in pain management (e.g., age, gender, race, ethnicity, and income), and issues related to pain management and licensure as well as drug utilization and surveillance utilization review. Pain experts should assess the educational content, including newsletters. The education should be accompanied by an assessment of knowledge and competency on an ongoing basis. Consideration should be given to using multiple educational formats and providing continuing education credits for licensed practitioners. • Each licensing board should develop a statement about the discipline's role in pain assessment and management, including minimum competencies and education requirements. Such documents should be developed with the input of pain specialists and address issues of pain management and licensure. Providers should be required to view the statement prior to licensing or reciprocity. The statement should be broadly available including via the Internet, and accompanied by practitioner educational efforts. • Physicians in residency programs must view the Board of Physician Quality Assurance (BPQA) video, "A Sense of Balance," before receiving licensure • All physicians currently practicing in Maryland must be required to view the BPQA video, "A Sense of Balance" prior to

	relicensure by 2007 • "A Sense of Balance," is a video presentation on drugs, chronic pain, and related subjects including appropriate prescribing of controlled drugs, over-prescribing, the addicted physician and identifying the drug seeking patient. This video presents the position of the Maryland Medical Board as well as that of the Federation of State Medical Boards on prescribing to patients with pain. • This video, "A Sense of Balance", should be digitally transferred to the BPQA website for increased access. • Educate licensing Boards for Maryland health care providers regarding pain assessment and management. This includes, but is not limited to, the Board of Physician Quality Assurance, the Maryland Board of Nursing, and the Maryland Board of Pharmacy. • Professional licensing boards must treat transgressions of untreated or under-treated pain aggressively. Appropriate remedial education should be made mandatory prior to actions against a practitioner's professional license. o Evidence-based guidelines (e.g. Federation of State Medical Boards guidelines) and pain experts should be used by licensing boards and the state DEA to investigate pain or analgesic related issues. o Consider a hearing regarding health care professionals concerns about regulatory scrutiny followed up responses from state licensing board and the Office of the Attorney General. • All health care providers (including, but not limited to, physicians, nurses, and pharmacists) should be required to have earned continuing education credits in the area of pain assessment and management before license renewal.

	• New policy and legislation relevant to pain assessment and management should be accompanied by educational initiatives targeting health care providers and institutions. • Work with Medicaid Drug Utilization reviewers to assist them in educating health care professionals. • Extended health care regulators/surveyors and personnel should be educated that it is not a negative indicator if a patient dies.

Reimbursement: Lack of reimbursement from insurance companies for pain therapies	• Mandate via the Insurance Commission or legislation that insurers in Maryland provide a uniform pain assessment and management benefit for all age and income groups that would include, but would not be limited to:
	  • Inpatient and outpatient referral to a pain specialist for pain assessment and treatment planning, short and long-term multimodality treatments, and follow-up, including side-effect management.
	  • Follow-up by licensed health care professional including non-prescribers (e.g., home health nurses, clinical specialists) to provide education, assess adherence, and work with the client/significant other and prescriber to maximize pain management therapy.
	  • Uniform minimal reimbursement for pharmacologic and scientifically based non-pharmacologic pain management therapies regardless of therapeutic medication class, choice of drug or therapy, method of medication delivery (i.e., route), site of service, or disease phase. Therapeutic interventions to manage pain including palliative pain interventions (chemotherapy, radiation therapy, and radioisotope therapy), pharmacologics (long and short acting analgesics, adjuvants, and side-effect medications), non-pharmacologics (e.g., physical therapy, acupuncture, and behavioral interventions), interventional procedures (e.g., temporary and permanent nerve blocks) and associated durable medical equipment.
	  Consideration should also be given to the following items.

	○ Minimizing drug premiums/co-pays while keeping the benefit sustainable and attractive ○ Assuring uniformity of coverage across the Medicare and Medicaid programs and coordination of benefits between programs, including hospice. ○ The components and effect of Medicaid drug utilization review (e.g. the impact on limiting drug quantities/refills/co-payments/# of prescriptions per month/pharmacy dispensing fees, MD prescribing practices, referrals to Medicaid Fraud Control Units or Surveillance and Utilization Review programs ○ facilitating seamless, timely, and adequate reimbursement of claims ○ rapid assessment by a team of pain experts of new therapies for inclusion in minimum uniform coverage benefit. • Extend assistance for payment for pain therapies for patients at 250% of poverty levels. • Insurers should be encouraged to offer a discount on malpractice insurance for providers completing continuing education and demonstrating competency in the area of pain assessment and management.
Health Care Systems: Lack of consistency within different health care systems regarding compliance and adherence to standards for pain management	• Licensed health care facilities, physician offices, home health agencies, hospices, and clinics not accredited by the JCAHO (e.g., extended care facilities, nursing homes, freestanding radiation oncology centers, hospices, home health agencies, pain clinics) should be held to pain assessment and management standards similar to JCAHO standards by the applicable state licensing agency. o Develop and test an external source of norms to which all health care facilities/clinics/agencies/physician offices assessing or treating patients in pain would be accountable for. Tie financial reimbursement to meeting quality standards. • Reduce limitations to prescribing pain medications (e.g., specific

	dose required instead of a dose range) and medications for side effects (e.g., use of haloperidol for nausea and vomiting) in extended care facilities • Scrutiny by institutions for disparity-related pain management issues. • Information about a patient's pain management regimen is transferred with any discharge/transfer of care. o Consideration should be given to using an electronic format that includes electronic monitoring under the guidelines of the Federation of State Medical Boards. • Develop standardized definitions for pain specialists and pain treatment centers that describe service scope (Consider the findings from the Donoghue Connecticut Pain Project and other national pain organizations).
Access to Pain Management Therapies: Lack of access to pain management therapies and presence of cultural, age, gender, and income disparities within the health care system.	• Patients experience delays due to the need for prior authorizations for non-formulary medications and more advanced pain management techniques, particularly in the Medicaid system. o Convene an independent council to improve and accelerate the process relative to prior authorization of non-formulary medications and invasive techniques used in pain management. The commission should work to reduce excessive co-payments for non-formulary medication if the non-formulary medication is the best medication for a particular patient. • Pharmacies should be required to have pain management medications, particularly opioids, available in stock. • Ensure that excessive restrictions do not exist on the number of pills prescribed, prescription renewals, and phone in/ faxed/ electronic prescription ordering for analgesics. • Encourage the establishment of multidisciplinary pain treatment centers and pain specialists in multiple health care disciplines. • Ensure equal access to pain assessment and management for the elderly, children, women, and minorities. • Require via legislation that patients are referred to a pain

	specialist for unrelieved pain in a timely fashion and information about plan of care is communicated between providers and institutions at the time of discharge/transfer. • Develop and make available in a variety of media a list of pain resources including, but not limited to, pain specialists, pain experts, pain clinics, hospices, medical schools, and pain specialty consumer groups. Consider the Donoghue Connecticut Pain Project as a model. • Develop, staff, and publicize a pain management hot line. Consider a model similar to Palliative Care Hotline. • See 'Reimbursement Issue" section
Research: Lack of scientific research regarding assessment and treatment of cancer pain	• Encourage and promote research in such areas as: o Pain assessment tools particularly for minority populations and populations that are unable to advocate for themselves because of limited communication skills o Low-cost medications for pain management (for example, methadone) o Outcomes analysis (i.e., long term opioid use, opioid rotation/tolerance/addiction, pain quality tool for use by surveyors/accrediting bodies, and the financial/quality impact of components of this project and associated legislative changes) o Cognitive behavioral, complementary and alternative therapies o Guidelines for the assessment and management of specific types of pain (i.e., neuropathic) o When to refer patients to pain specialists and the accompanying credentials for certification of such specialists o Pediatric cancer pain management o Changing clinical practice and clinician's fear of regulatory scrutiny o Improving patient adherence o Occurrence of cancer related pain by cancer, stage, type of cancer pain, and other factors (ie., demographic

	factors and longitudinal trajectory) • Encourage pharmaceutical companies to continue research and development of new treatments for the management of pain.
Public Information and Education: Lack of public knowledge and awareness of pain management practices and referral sources	• Partner with organizations such as the American Cancer Society, the American Chronic Pain Association, the American Pain Foundation, and the Maryland Pain Initiative to conduct a comprehensive, statewide, and culturally sensitive public health campaign to promote pain assessment and management. o This campaign should utilize public health strategies and include an educational media campaign. The message should include a focus on the patient's right to adequate pain management and their and their health care provider's responsibilities in the process, dispelling the myths about pain medications, options that exist for pain management, and instructing patients to communicate with their health care provider about pain. • Promote outreach to consumer/patient groups focused on pain. • Provide culturally sensitive, and language appropriate pain control information to all patients/their surrogate at the time of diagnosis and throughout their disease process. Consider the use of educational materials already in existence (ACS, NCI, NIH, etc.) o Develop a mechanism to disseminate standard, medically appropriate information on specific pain medications to patients. o Inform patients/surrogate of options, alternatives, and potential outcomes and involve them in treatment selection. • New policy and legislation relevant to pain assessment and

	management should be accompanied by educational initiatives targeting health care providers and institutions.
Complementary and alternative therapies: Lack of awareness of and reimbursement for complementary and alternative therapies (see definitions below)	• Encourage support for and use of scientifically validated complementary and alternative therapies for pain control as individual measures or in conjunction with traditional pain management methods. • Support research in this area • Encourage patients and providers to discuss these therapies • Advocate for reimbursement of these therapies by insurance companies.
Assessment: Inadequate pain assessment	Promote the use of population specific, standardized, reliable, valid, pain assessment tools. Special consideration should be given to the effect of pain on patient function and to patients with limited ability to communicate or advocate for themselves (e.g., children, people with language barriers, patients with dementia).

Legislative Issues: Lack of robust legislation to ensure the right and provision of pain assessment and effective pain management in all health care settings for all patients.	<u>Existing legislation changes:</u> • Review the Advanced Directive and Living Will Forms for clarity. Make the POA the lead form instead of sandwiching it between the AD and the Living Will. Consider eliminating the living will in favor of a revised Advanced Directive. Instructions should be written to strongly favor Power of Attorney (POA), supported if the declarant wishes with more specific guidance (i.e., bolded). Advance directives/living wills should: o include a bolded statement that urges the declarant to discuss his/her wishes with the person given the POA. o include a check box to signify the person's preference for the provision of effective pain control and comfort measures, and to encourage a discussion with their health care proxy regarding specific measures. *For example, " I direct that whatever my condition I be provided with medications to relieve pain and suffering in accordance with accepted health care standards."* o Not include the statement "(4) I direct that no matter what my condition, medication not be given to me to relieve pain and suffering, if it would shorten my remaining life" since this is related to the principle of double effect, which current literature does not support as a real issue. <u>Potential legislative action:</u> • Modify state regulations to facilitate availability and prescribing of pain medications • Modify state regulations to mandate that insurers in Maryland provide a uniform pain assessment and management benefit for all ages, income groups, phases of the disease trajectory and regardless of site of care (see Reimbursement section). • Develop a Pain Patient's Bill of Rights based on a similar California bill (1997) CAHLTH & S 124960. This bill should include: o some mechanism of enforcement o a course of action if the individual is denied pain care.

	o A requirement for regular assessment and charting of pain in physician offices, health care clinics, and licensed health care facilities. o licensed health care facilities as well as clinics, treatment centers, home health agencies, hospices, and physician offices adhere to an external pain assessment and management standard that defines minimum practice and quality monitoring requirements. o A requirement for transfer of pain-related information when care is transferred (i.e., at discharge, between physician practices). o A requirement for an explanation of pain management options, alternatives, and potential outcomes as well as involving the patient/surrogate in treatment selection. • Provide funding for the educational initiatives put forth in this document, including the Health commission and grass root volunteer organization efforts. <u>Future legislation/regulations should:</u> • Ensure balanced policy concerning opioid use (i.e., diversion and effective pain treatment). • Utilize the American Alliance of Cancer Pain Initiatives Statement on State Prescription Monitoring Programs as needed. • Consider at a minimum information from University of Wisconsin Pain and Policy studies group, pain focused issues from the Journal of Law and Medical Ethics, relevant publications/audio tapes from the Last Acts, and the Propac report on Medicaid.
Adherence: Lack of patient adherence to prescribed therapies:	Whereas patient non-adherence can be attributed to multiple causes outlined in this document, the recommendations suggested in this document to address issues listed below are necessary to reduce non-adherence and maximize pain relief. Causes of non-adherence include, but are not limited to: • cost of and lack of reimbursement for pain management services, therapies, and follow-up (especially outpatient ~~visits~~

	services) • use of short-acting medications to treat on-going or recurring pain • fear of addiction • side-effects • cultural, family, and media influence • inadequate patient/family education

Conclusion: The recommendations of this report should be submitted to the Maryland State Advisory Council on Pain Management. Any panel addressing the recommendations above should consider new findings, including but not limited to those presented by/in the University of Wisconsin Pain and Policy studies group, Journal of Law and Medical Ethics (see pain related special issues), *Expanding Prescription Drug Coverage in Medicare: Issues for End-of-Life Care* and *Medicaid and End-of-Life Car*e and other relevant publications/audio tapes from the Last Acts, The Propac report on Medicaid, *Breaking Down the Barriers to Effective Pain Management: Recommendations to improve the assessment and treatment of pain in New York State*, the Maryland Pain Initiative, the American Pain Foundation, and the Maryland State Advisory Council on Pain Management.

Definitions:

Pain management: a comprehensive approach to the needs of patients, residents, and clients served who experience acute or chronic pain (adapted from Joint Commission Accreditation of Health Care Organizations, *Pain Assessment and Management: An organizational approach* (Oakbrook Terrace, Illinois: JCAHO 2000))

Complementary and alternative medicine (CAM): a group of diverse medical and health care systems, practices, and products that are not presently considered to be part of conventional medicine. While some scientific evidence exists regarding some CAM therapies, for most there are key questions that are yet to be answered through well-designed scientific studies—questions such as whether they are safe and whether they work for the diseases or medical conditions for which they are used.

- Complementary medicine is used together with conventional medicine. An example of a complementary therapy is using aromatherapy to help lessen a patient's discomfort following surgery.
- Alternative medicine is used in place of conventional medicine. An example of an alternative therapy is using a special diet to treat cancer instead of undergoing surgery, radiation, or chemotherapy that has been recommended by a conventional doctor.

(Source : http ://nccam.nih.gov/health/whatiscam/)